PERSONNEL PROCEDURES AND TRANSACTIONS GUIDE

2015

This *Guide* is published to familiarize Department Heads with various personnel actions made in connection with an employee's initial employment, changes in employment status or absence from work. It is not intended to be all inclusive and is subject to change. All forms attached to this guide are also available on the Town's website under the Human Resources link at www.darienct.gov .

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I. FILLING A POSITION

All vacant positions must be budgeted and approved for hiring prior to recruitment and appointment. The Town has implemented a position control process that begins with the Department Head completing a *Position Request Form* and submitting it to the Human Resources Department for review. The Department must provide all relevant information concerning the type of action being requested. This form is required before any position can be approved except for Park and Recreation/Youth Commission summer seasonal positions such as lifeguards and camp counselors. Once the Human Resources Department has reviewed the request, the form is forwarded to the Finance Department for review and recommendation, and then it is forwarded to the Town Administrator for final approval. A copy of the *Position Request Form* is attached.

Town of Darien
POSITION ACTION REQUEST FORM

Department Heads must complete this form and submit it to Human Resources for processing for any new hire or change to an existing position.

ACTION REQUESTED BY DEPARTMENT	
Fill current/anticipated vacancy:	Create and fill new position:
Reclassify/upgrade position:	Change number of hrs. of current/anticipated vacancy
Department requesting action:	

POSITION INFORMATION	
Job Title:	Rate of pay:
Budget account:	
Reason for Vacancy:	
Name of Previous Incumbent:	
Number of hrs./week:	If a vacancy, is this a change in hours/wk.
Permanent Full-Time:	Permanent Part-Time: Number of hrs. /week
Temporary/seasonal position:	Number of weeks anticipated
Proposed start date:	
Is the proposed employee already employed by the Town?	
If so, current position and Department	
Department Head Signature:	Date

HUMAN RESOURCES REVIEW	
Position already exists:	Position has to be created:
Position number:	
Current employee is eligible to work as temp/seasonal:	
Number of hrs./week eligible to work:	Number of weeks eligible to work
Upgrade/reclassification approved:	Effective Date:
Signature of Human Resources Director	Date

FINANCE REVIEW AND RECOMMENDATION
OK to proceed as requested:
OK to proceed as requested except:
Other:
Forwarded to Town Administrator:
Finance Director Signature/Date

TOWN ADMINISTRATOR REVIEW	
OK to proceed as noted by Finance: Approved:	Denied:
Return to HR:	
Signature of Town Administrator	Date

HUMAN RESOURCES ACTION
No action due to denial of request:
Name of Employee Hired:
Date of Hire:

DETERMINING THE APPROPRIATE POSITION TO BE FILLED

Once you become aware of a vacancy in your department, you should review your department needs to insure that the vacant position is actually the appropriate position for the department. Each time you have a vacant position, you are presented with an opportunity to adjust your table of organization and to realign your workforce to insure the needs of the department are being met by the existing staffing composition. This may require a review of the mission and objectives of the organizational unit and a determination as to the tasks to be performed in accomplishing those objectives. It will also require you to determine the most efficient methods, work processes, equipment and techniques to use for performing the objectives.

If, after you perform the analysis, you decide that the vacant position no longer meets the needs of the department, you can modify the position, create a new position, or fill a different but existing position than the one vacated. For example, if a Driver has recently resigned, the Department may not need another Driver because of a change in duties, equipment or objectives. Instead the Department needs may better be met by a position that requires a higher or lower set of knowledge, skills and abilities.

MODIFYING A JOB OR JOB DESCRIPTION

Once you have reviewed the needs of the department and determined the appropriate position to fill, you should review the existing job description to determine if it accurately reflects the duties and responsibilities of the position and the needs of the department. If the existing job description is out-of-date, you should revise it to more accurately reflect the duties actually being performed. If the job has evolved into one that requires greater levels of skill, knowledge or education, then the position may be appropriate for an upgrade/reclassification.

If you want to fill a newly created position or significantly change an existing job description, you will need to draft a proposed job description and rate of pay for the position. If the position is represented by a Union, it will have to be sent to the Union representative for review. Although the Town has ultimate authority over the job duties the position will perform, the Union has the right to negotiate over the rate of pay. If the parties cannot reach an agreement on the appropriate rate of pay, the parties can submit the issue to an arbitrator for resolution.

A job description contains a general statement describing the position followed by more detailed statements of the type of work and responsibilities that characterize the position. A consideration of such factors as variety and difficulty of work, work hazards, relative independence of action, supervision received and exercised, and other distinguishing features are also included. The job description should include the minimum educational or experience requirements for the position and if any special license or certifications are required. Each time a job description is created or modified, the date of the action should be included on the job description.

When developing a job description, the following format should be utilized:

Job Title: SALARY GRADE

Job Summary: This summary should include the general purpose and responsibilities of the position.

Supervision Received:

Supervision Exercised:

Equipment/Vehicles Operated: If applicable

Examples of Essential Duties: This section illustrates a more specific picture of the duties assigned to positions in the class in terms of typical examples rather than an all-inclusive list of assignments.

- DUTIES SHOULD APPEAR IN ORDER OF IMPORTANCE
-
-
- Final example of duties should consist of a statement such as "performs related work as assigned".

Special Requirements: List specific licenses or certificates needed by an employee. Such licenses are those required for persons engaged in certain occupations such as law, medicine, or jobs requiring the operation of dangerous equipment.

Minimum Qualifications Required: This section sets forth the knowledge, skills, and abilities into quantifiable training and experience standards. It sets forth the minimum qualification requirements which an applicant for a vacant position in the class should possess at the time of appointment.

Physical Requirements: This section should specify conditions of physical endurance or emotional stability highlighted by demand of the position, where such conditions are primary selection factors. The essential physical requirements to perform the job

Date Created:

Date(s) Revised:

HUMAN RESOURCES DEPARTMENT

C A R E E R O P P O R T U N I T Y

Title: **PARKING RANGER** **GRADE LT-1**

Job Summary: Parking regulation compliance and manual labor.

Vehicles & Equipment Operated: Pickup truck, small dump truck, van, passenger car or utility vehicle. Power mower, chain saw, weedwacker, snow blower, gravely plow, line striper and similar tools; hand-held computer devices.

Examples of Essential Duties:

- Patrols permit and voucher parking areas daily to monitor compliance with and enforce parking regulations.
- Issues violation notices as needed.
- Maintains railroad station facilities including platform lights and lot lighting systems.
- Cuts grass at stations.
- Erects and repairs informational, regulatory signs related to parking facilities.
- Removes snow from railroad station platforms and sidewalks.
- Trims shrubs, picks up litter.
- Plows snow with small truck.
- Paints parking stalls.
- Occasionally directs traffic at parking facilities.
- Does related work as required.

License Required: A current Connecticut Motor Vehicle Operator's license.

Physical, Mental Exertion/Environmental Conditions: Ability to work 16-hour shifts with only normal breaks. Ability to lift 60 pounds from ground level to shoulder level, carry same 20 feet and place back on ground.

SUMBIT AN INTENAL TRANSFER REQUEST TO YOUR DEPARTMENT HEAD OR HUMAN RESOURCES NO LATER THAN AUGUST 18, 2008
POSTED 07/14/15

PERFORMANCE EVALUATION

The Town maintains high standards for employee job performance. It is the Town's goal to support employees in the achievement of their full potential. The Town's evaluation process focuses on the individual employee's contribution to the Town services, as well as the abilities the employee demonstrates in doing so. The Town formally evaluates most employees once per year. Areas such as; accomplishments during the prior year, performance against job standards and objectives, areas of needed improvement, and goals for the upcoming year are all reviewed during the evaluation. The evaluation process is the basis for salary and benefit decisions for the upcoming year. In addition, supervisors are urged to evaluate an employee's progress throughout the year through direct meetings and in writing as necessary.

The purpose of the performance evaluation is to evaluate an employee's job performance and response to training. The employee performance evaluation forms and the discussion between employees and their supervisor are designed to create accountability in the performance evaluation process. Acknowledgement of employee strengths and accomplishments will be addressed along with the development of an action plan where appropriate. The employee's supervisor is responsible for completing the applicable employee evaluation form. The employee's supervisor will meet with the employee to discuss the evaluation and the employee's individual goals or job requirements for the coming year. Employees and their supervisors are expected to include any written comments, and both employee and supervisor are expected to sign the form. If necessary, the supervisor will develop and attach a professional

development plan. The employee's supervisor will submit the completed and signed performance evaluation, with attachments (if any), to the Town Administrator for review and approval as necessary. The employee's supervisor then submits the employee's completed and signed performance evaluation, with attachments (if any), to the Human Resources Department to be included in the employee's personnel file. Employees must be allowed to review any and all evaluations. If there is anything in the evaluation that an employee disagrees with, the employee can submit a rebuttal or explanation, which the employer must attach to the evaluation and place in the employee's personnel file.

Employees may receive one or more performance evaluations during their initial probationary period, and as otherwise provided by state law, Town policies and procedures, and, if applicable, the collective bargaining agreement. Employees may also receive a performance evaluation in the event of a promotion or when their job duties and responsibilities or job performance have changed significantly and it warrants review. Probationary employees must be evaluated by the end of their first 90 days of continuous service.

Supervisors are required to use the *Employee Evaluation Form* (See attached) for bargaining unit employees. Department Heads and other non-bargaining unit supervisors are evaluated using a different evaluation form and process which includes an *Employee Self-Assessment.*

Town of Darien

EMPLOYEE EVALUATION FORM

EMPLOYEE'S NAME: _____

REASON FOR ACTION:	
☐ Compliment:	☐ Excessive Absence of Lateness:
☐ Unsatisfactory Work Performance:	☐ Insubordination:
☐ Disruptive Work Behavior:	☐ Violation of Department Rules
☐ Refusal to Perform Assigned Work:	☐ Violation of Safety Rules
☐ OTHER:	

DESCRIPTION OF INCIDENT (IF APPLICABLE): Provide in a complete but concise manner, relevant information regarding the employee's performance, actions, or behavior displayed. (Attach additional sheet(s) if necessary).

_____

_____

_____

_____

ACTION TAKEN BY SUPERVISOR:	
☐ Formal Supervisory Commendation (Written)	☐ Written Commendation Recommendation
☐ Verbal Supervisor Warning	☐ Written Reprimand Recommendation
☐ Written Supervisory Warning	☐ Suspension Recommendation
(Complete next section)	*(Supervisor signs and forwards)*

CORRECTIVE ACTION TO BE TAKEN: _____

_____

_____

Notice: The employee is advised that any further violation of performance standards, rules regulations or policies may result in further discipline up to and including suspension from duty and/or termination of employment.

EMPLOYEE'S COMMENTS

☐ I agree with the action taken.

☐ I disagree with the action taken for the following reasons: _____

_____

_____

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

This document shall serve as a Written Record to the Employee regarding the described performance or conduct. The employee is advised that any further violation of rules regulations or policies may result in further discipline up to and including suspension from work and/or termination of employment.

☐ Copy to Personnel File and Employee ☐ Employee met with Supervisor on – Date: _____

☐ Remove from Personnel File (if applicable) on _____

DETERMINING THE APPROPRIATE RATE OF PAY

If you have created a new position or significantly changed the job duties and responsibilities of the position, you will need to recommend an appropriate rate of pay for the position. When determining what rate of pay is appropriate, consideration should be given to the education, knowledge, skills and abilities, and level and complexity of the principal duties and responsibilities, required for the position as well as the budgeted salary for the position. The rate should be set in accordance with other positions requiring similar skills, education and knowledge and above the rate for positions requiring less skills, education, and knowledge and below the rate for positions requiring more skills, education and knowledge.

A rate adjustment to an existing position may be necessary as a result of a significant change in existing duties or if the existing rate is out of alignment with the prevailing rates in the relevant job market. Occasionally, an increase in pay is required because the rate is inconsistent with internal positions even though it may be comparable with the external job market.

IDENTIFYING QUALIFIED INDIVIDUALS FOR THE POSITION

The Town of Darien does not utilize a civil service testing process for hiring employees. However, the Town has implemented various policies and procedures for recruiting and hiring individuals that are designed to insure the most qualified individual is selected for each position.

If the position to be filled is not represented by a Union, then the Town can advertise the position internally or externally and consider existing employees or candidates from outside the workforce. External candidates should submit an application and internal candidates may submit either an application or a request for transfer form, depending on the position. If the position is represented by a Union, then the posting and recruitment requirements of the contract should be followed. Refer to the specific collective bargaining agreement for details.

The selection of applicants for vacant positions will be determined based on the individual's experience and qualifications for the position to be filled. Using fair and relevant selection criteria, the Department Head and Human Resources Department will review the credentials of each applicant and determine who possesses the minimum qualifications. A pool of the most qualified candidates shall be identified and scheduled for interviews from those applicants who meet the minimum qualifications. Selection procedures and methods will be related to the duties and responsibilities of the vacancy to be filled.

After candidates have been identified for personal interviews, the Department Head and Director of Human Resources will decide who should conduct the interviews and what questions are appropriate. Some types of positions are best filled by using interviewing or screening panels that may include representatives from relevant Town boards or commissions or

employees from other towns. Panel members ask each candidate the same questions and make a recommendation or determination of the appropriate candidate.

In other cases, it may be appropriate for the Department Head and Director of Human Resources to conduct the interviews. However, it is rarely a good idea for a Department Head to conduct an interview alone.

Interview questions should be designed to determine the candidate's qualifications and suitability for the position and should not include questions designed to illicit the candidate's age, marital status, children, child care arrangements or other illegal areas of inquiry. All questions are to be reviewed by the Director of Human Resources to ensure compliance with all legal requirements.

Once a candidate has been identified as the best person for the position, Human Resources will check the person's references. After the reference check is complete, the Department Head or the Director of Human Resources can make a verbal offer of employment. If the candidate accepts the offer, he/she will receive a written confirmation of employment from the Human Resources Department. If the employee is required to have a physical examination before his employment begins, the appropriate paperwork will be included in his/her letter. An example of an offer letter is attached.

Unsuccessful candidates will be notified that they were not selected for the position in writing, when possible. An example of a rejection letter is attached.

Finally, before the employee can be placed on the payroll, the Department Head, Human Resources Department, and Finance Department must sign an *Employee Change Form.* A copy of the form is attached.

INTERNAL JOB POSTING APPLICATION

Current Position:	**Current Department:**
Position Applying For:	**Department Applying To:**
Employee Name: (last, first, middle)	**Home Phone Number:**
Address: (Number & Street, R.D. or P.O. Box)	**City, State and Zip Code:**
Signature:	**Date:**
Supervisor Signature:	**Date:**

Please return completed application along with a resume to the Human Resources Department.

TOWN OF DARIEN

HUMAN RESOURCES DEPARTMENT

W. LEE PALMER
DIRECTOR

Date:

Name:

Dear:

I am pleased to confirm our offer to you to serve as [Title] for the Town of Darien [insert department] commencing on _____. The annual salary for the position is $_____. You will be paid on a bi-weekly basis.

This offer is contingent on you providing proof from a physician that you are in good health for the type of work you will do and have no evidence of drug abuse. You will be reimbursed up to $_____ for the costs incurred by you to provide this documentation.

You will become eligible to participate in the Group Health Insurance/Prescription Drug Plan and Delta Dental on _____. Employees share the cost of group health insurance by paying a percentage of the premiums as well as co-payments for office and hospital visits.

You will be enrolled on the date of your employment in the Group Life Insurance Plan, which is paid by the Town of Darien. This benefit is equivalent to your annual salary to a maximum of $_____. You will also participate in the Long Term Disability Plan with a benefit of 60% of basic earnings.

Employees are required to participate in the Town of Darien Pension Plan with full service credit commencing one month after your date of hire. Participants are vested after five (5) years of continuous service and contribute 5% of their salary toward this benefit. A Tax Deferred 457 Plan is also available to employees.

You will accrue sick leave at a rate of one (1) day per month and vacation at a rate of 1.25 days per month. Additionally, you are eligible for two (2) personal days a year. Sick leave may be carried over from year to year but you will not be paid for unused sick leave upon termination of your employment. Your accrued vacation should be used in the year it is accrued; however, you are permitted to carryover up to two years worth of accruals. Accrued and unused vacation will be paid to you upon termination of your employment. However, unused personal days cannot be carried over from year to year nor do they have any cash value.

The Town observes the following 13 paid holidays:

New Year's Day
Columbus Day

Martin Luther King, Jr. Day	Veterans' Day
Presidents' Day	Thanksgiving Day
Good Friday	Day after Thanksgiving
Memorial Day	Christmas Eve
Independence Day	Christmas Day
Labor Day	New Year's Eve (early closing)

This letter simply highlights the major benefits. The documents you will receive when you commence your employment will provide more detailed information on the terms of the specific plans.

On behalf of the Town of Darien, I congratulate you on your new position and wish you every success.

Sincerely,

W. Lee Palmer
Director of Human Resources

cc: Personnel File

Town of Darien

NEW EMPLOYEE ACTIVATION FORM

EMPLOYEE NUMBER: _____ (generated by Payroll)

New employee completes rows 1 through 14 below:

1. Social Security Number: _____
2. First name & middle initial: _____
3. Last name: _____
4. Street Address: _____
5. City & State: _____
6. Zip code: _____
7. Phone Number: _____
8. Emergency Contact/Relationship: _____
9. Emergency Number: _____
10. Date of birth: _____
11. Male or female: _____
12. Race (Optional): _____
13. Single or married: _____
14. Have you ever been a member of the Town of Darien Pension Plan? *(circle)* Yes No

Employees Signature:

_____

.....

Rows 15 through 24 to be completed by the Employer:

15. Department: _____
16. Position: _____
17. Fund/Organization/Object: _____
18. Full or Part-Time *(Specify hours/week & schedule of days):* _____
19. Bargaining Unit: _____
20. FT - Grade & Step: _____
21. PT – Hourly Rate: _____
22. Effective Date of Hire: _____
23. Eligible for Police Officer Education Stipend? *(circle)* Yes No Level _____
24. Health/Dental? *(circle)* Yes No If yes, specify plan and option selected: _____

Approved by: _____

Date: _____

CHANGES TO AN EMPLOYEE'S POSITION AFTER THE INITIAL EMPLOYMENT

Sometimes a position changes or evolves over time and those changes may require updating the job description, and may also require modifying the rate of pay to more accurately reflect the level and complexity of the position.

UPGRADING OR RECLASSIFYING A POSITION

It is not appropriate to upgrade a position merely because the person has been working in a position for a long time or because she/he produces a high volume of work. Job classification is based on grouping positions by the level and complexity of the job functions performed. If the needs of the Department have changed so that a certain position is no longer needed, then that department should review its table of organization to determine the appropriate skill mix and level of positions required. This may result in the elimination of one or more positions and the creation of other positions. It may also require that the Town to post positions and solicit qualified candidates for the positions.

For example, a request for an upgrade would not be appropriate for a Driver I who has either been permitted to perform Driver II duties due to the needs of the department or as a result of a Driver II's temporary absence from work. If the Department needs additional employees to perform Driver II work, it must request that an additional position be created and if approved, the position must then be posted and filled in accordance with transfer, vacancy or promotions policies and/or contractual requirements.

A different situation is when an employee's duties evolve over time due to changes in technology or to department functions or responsibilities. When an employee's principal (i.e. the majority) job duties have changed to a higher level, a revised job description should be created to include the new duties. Based on the level and complexity of the position and knowledge, skill, and ability required to perform the duties, an increase in pay may be appropriate. However, occasionally, although the type of work may have changed, the knowledge, skill and ability have not increased. In those instances, the job description should be updated with no increase in pay.

Once the Department Head and Director of Human Resources have agreed upon the job description, an appropriate pay grade will be set in accordance with jobs requiring similar or comparable knowledge, skills, and abilities.

Non-Union employees who work temporarily in a higher classification as a result of an employee's temporary absence from work or during a transition period may be eligible for a stipend while "acting" in the higher capacity. Once the employee is no longer in the "acting" capacity, the stipend will cease.

Requests for upgrades can be initiated by an employee, union representative or Department Head and must be submitted to the Director of Human Resources for a review of the duties of the position. The upgrade request should include a duties questionnaire and a statement supporting the request for a change to the existing job classification. The Director of Human Resources will meet with the employee and Department Head or supervisors as part of the process to determine whether an upgrade is appropriate.

The Director of Human Resources will then submit his/her recommendation to the Town Administrator for review and budgetary approval, if appropriate. The Town Administrator has the final approval of any upgrade.

II. WHAT TO DO WHEN AN EMPLOYEE HAS AN EXTENDED UNSCHEDULED ABSENCE

Occasionally, an employee may need to be absent from work due to injury, illness, personal reasons or civic duty. However, when an employee needs to be absent from work for an extended period of time, the Department Head is responsible for notifying Human Resources to insure that the employee's need for a leave and the duration of the leave is documented. This includes all potentially qualifying Family and Medical Leave (FMLA) events.

NON-WORK RELATED SICK LEAVE

Generally, employees are not required to produce a physician's note verifying the need for occasional absences from work due to non-work related illness or injury. The Public Works contract permits the employer to request proof of illness when an employee is absent for more than three (3) consecutive work days due to illness and is sick before or after a holiday. For other employee groups, if the supervisor has reason to question the validity of an absence, or if the employee has a patterned use of sick leave (to extend weekends or holidays) the supervisor may request a physician's note to verify the legitimacy of any absence or claim for a sick day. Attached is a "return to work" note that can be used to verify an absence due to a non-work illness or injury.

However, an employee who is frequently absent or is frequently absent before or after a weekend or holiday may need to be counseled or disciplined for abuse of sick leave. It is up to the Department Head to track the employee's use of sick leave and to take appropriate action to correct suspected sick leave abuse. Attached is a form that a supervisor can use to counsel or discipline an employee regarding sick leave abuse. If the employee is represented by a union, he/she may request that a union representative be present during any meeting that the employee reasonably believes may lead to discipline. However, the employee cannot delay the meeting by demanding that a specific union representative be present if that representative is unavailable.

FEDERAL FAMILY AND MEDICAL LEAVE ACT

When an employee is absent due to illness or injury for an extended period of time, the employee may qualify for a leave under the federal Family and Medical Leave Act (FMLA). Some employees may also be eligible for compensation under short term or long term disability.

Employees with more than 12 months of employment and who have worked more than 1,250 hours within that period are eligible for leave under the provisions of the federal Family and Medical Leave Act of 1993. Up to 12 weeks of protected, unpaid leave in a 12-month period are available with certain provisions for the birth of an employee's child or to care for such child; a child's placement with the employee for adoption or foster care; to care for a spouse, child, or parent (not parent-in-law) who has a serious health condition; or the employee's own serious health condition. An employee taking such leave must be restored to the same position or its equivalent. An employee is allowed to continue fringe benefits, such as health insurance, but may be required to assume this expense.

The Town has elected to define the twelve (12) week leave period on a rolling 52 week calendar basis and to require employees to utilize their accrued paid time off during the leave. Because an employee must be notified of the fact that the Town is considering the employee's leave as an FMLA leave and the employee must submit supporting medical documentation, it is important that you notify Human Resources as soon as an employee is out of work for three (3) or more days due to injury or illness. If an employee has indicated that he/she has scheduled an operation or other procedure in the future that will require him/her to be out of work for more than three (3) days, you must notify Human Resources so that the employee can be sent the FMLA leave request forms in advance.

The FMLA also permits a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness."

It is important to note that the caregiver protection provides more than double what is provided when an employee takes "traditional" FMLA leave. Employees are entitled to only one 26-week leave period to care for a wounded service member during the employee's employment. The leave may be taken on an intermittent or reduced-schedule basis, but all 26 weeks must be used during a single 12-month period.

The Act also provides up to 12 weeks of leave for employees who have a family member called up to or engaged in active military duty. In detail, the Act provides up to 12 weeks of FMLA leave for an employee with a spouse, son, daughter or parent who: (1) is on active duty in the Armed Forces in support of a contingency operation; or (2) has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation. A "contingency operation" is an action or operation against an opposing military force.

Town employees are not eligible for leave under the State of Connecticut's family and medical leave act. (C.G.S. 5-248a)

Employees must submit a physician's note certifying that their absence is due to a non-work related injury or illness with an anticipated return to work date or the date of the next physician's appointment to the Human Resources Department. **THE TOWN WILL NOT ACCEPT A PHYSICIAN'S NOTE EXCUSING AN EMPLOYEE FROM WORK "UNTIL FURTHER**

NOTICE" WITHOUT THE DATE OF THE NEXT PHYSICIAN'S APPOINTMENT. The employee must submit an updated medical form after each physician's appointment. A copy of the medical documentation form is attached.

Employees who do not submit medical documentation supporting their absence from work or who do not submit updates concerning their status may be considered on unauthorized leave and will not be paid for the leave and may be subject to disciplinary action, up to and including termination of their employment.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number 1235-0003
Expires 5/31/2018

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____ _____
Employer Representative

DATE: _____ _____

On _____, you informed us that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

_____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.

_____ You have not met the FMLA's hours of service requirement.

_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

___ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____is/____ is not enclosed.

___ Sufficient documentation to establish the required relationship between you and your family member.

___ Other information needed (such as documentation for military family leave): _____

_____

_____

___ No additional information requested

CONTINUED ON NEXT PAGE

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation)

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - _____ the calendar year (January – December).
  - _____ a fixed leave year based on _____.
  - _____ the 12-month period measured forward from the date of your first FMLA leave usage.
  - _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

  ____Applicable conditions for use of paid leave: _____

  _____

  _____

  _____

  _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number 1235-0003
Expires 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT

OMB Control Number 1235-0003
Expires 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number 1235-0003
Expires 5/31/2018

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

SHORT TERM DISABILITY

The members of the Town Hall Employees Union have access to a short term disability plan that pays an employee who is absent due to a non-work related injury or illness 60% of his/her regular daily rate of pay beginning on the 8th calendar day following the employee's last day worked for a period of up to six (6) months of continuous absence. The employee may supplement the short term disability pay by using accrued unused paid time off (sick, vacation and personal leave) to receive a full pay check. If the employee does not have any accrued paid time off to supplement the short term disability pay, he/she will only receive the 60% payment for the duration of the leave. It is important that the supervisor notify Human Resources when an employee is out of work for an extended period of time so that the employee can be issued a letter explaining the short term disability benefit. An example of a letter notifying an employee he/she is on short-term disability is attached.

TOWN OF DARIEN

HUMAN RESOURCES DEPARTMENT

W. LEE PALMER
DIRECTOR

Date:

Dear:

RE: Short Term Disability

According to our records, you were out of work due to a non-work related illness beginning on _____ and returning to work on _____. This letter will confirm that in accordance with the Agreement reached between the Town and the Union you were placed on Short-term Disability (STD) leave from _____ through _____. An Agreement with the Union was needed because you came to work for a few hours during the seven day waiting period. In accordance with the short term disability policy, your pay for these two (2) days will be comprised of 60% from STD with sick leave making up the remaining 40%.

Please note that because this leave appears to qualify under the Family and Medical Leave Act, which provides you up to twelve (12) weeks of unpaid leave in a rolling 52 week period during which time your benefits and position will continue unaffected, the leave will be designated as a FMLA leave.

If you have any questions or concerns, please feel free to contact me.

Sincerely,

W. Lee Palmer
Director of Human Resources

LONG TERM DISABILITY

Town employees who do not have access to short term disability may be eligible for long term disability after six (6) months of absence due to a non-work related illness or injury. This coverage is provided by The Standard Insurance Company, and the employee must complete an application and meet the requirements set forth by the insurance company policy. Town Hall Union Employees are not eligible for LTD.

LEAVES DUE TO WORK-RELATED ILLNESSES OR INJURIES

If an employee suffers a work-related injury or illness, he/she should immediately go to the Darien Immediate Medical Care Center or Stamford Hospital Emergency Department for prompt assessment and treatment. The employee's supervisor must complete a *First Report of Injury* form and fax it to the Workers' Compensation Carrier as soon as possible. The supervisor is also required to complete an accident report to be submitted to the Safety Committee for review. These forms are attached.

Under the Connecticut Workers' Compensation laws, there is a three (3) day waiting period before an employee is eligible to receive pay for a work-related injury. The day of the injury does not count towards the waiting period. Therefore, in order for the employee to be paid for the first three (3) days following the day of injury, he/she must use sick time. However, if the disability continues for seven (7) days, Workers' Compensation pay will be retroactively applied from the date of the injury and the sick time converted to Workers' Compensation (WC).

For example, based on the number of days the employee is out of work, his/her time and attendance records should be recoded as follows:

DATE OF INJURY	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY7
Day paid by Town	SICK	RTW	RTW	RTW	RTW	RTW	RTW
Day paid by Town	SICK	SICK	RTW	RTW	RTW	RTW	RTW
Day paid by Town	SICK	SICK	SICK	RTW	RTW	RTW	RTW
Day paid by Town	SICK	SICK	SICK	WC	RTW	RTW	RTW
Day paid by Town	SICK	SICK	SICK	WC	WC	RTW	RTW
Day paid by Town	WC	WC	WC	WC	WC	WC	WC

RTW-Return to Work, WC-Workers' Compensation

Please be sure that when an employee misses work due to an alleged work-related injury, that the employee understands that he/she must be

examined by a physician to verify that the injury is related to a new or prior work-related injury. This applies regardless of whether the employee misses one or more days of work or if the employee leaves work early due to a reoccurrence of a prior workers' compensation injury.

If the employee is not examined by a physician or if the injury is not verified, then the employee must charge the lost time to his/her own sick time. Each absence from work related to a physician's appointment or injury or illness from a prior workers' compensation injury must be substantiated each time by a physician's note.

Once the Employer's *First Report of Occupational Injury or Illness* (see attached) has been submitted to the workers' compensation carrier, the employee's injury will be assigned a case number and all treatment and payments will be paid under that number.

The Town implemented a managed care plan for workers' compensation injuries effective July 1, 2008. All work related illness or injuries incurring on or after that date must be treated by a physician in the managed care network. If an employee seeks treatment from a physician outside of the network, the claim may be denied and all medical expenses denied. A laminated pocket card with the managed care network and workers' compensation carrier contact information is available in the Human Resources Department.

Any work-related injury or illness that occurred prior to July 1, 2008 is not subject to the managed care plan and the employee can continue to be treated by the physician of his/her choice.

CIRMAcare

Print Form

CIRMA Injury Reporting Information

Report Claims at NetClaim.net or 1-800-OK-CIRMA

Keep this Form for your own Records—Do Not Submit to CIRMA

Event Date/Time

Incident Date and Time: _____ Employer Notified: _____

Reporter & Location Information

Reported by: _____ Title: _____ Phone Number: _____

Location Code: _____ Location Name: _____ Address: _____

Claimant Information

Social Security Number of Claimant: _____

Claimant Name: _____

Home Phone: _____ Work Phone: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: _____ Gender: ☐ Male ☐ Female

Employment

Job Title: _____ Status: _____

Claimant's Supervisor: _____ Title: _____ Phone: _____

Incident

Description of the Injury: _____

_____

Cause: _____ Body Part: _____

Nature Code: _____

Medical Provider (if known): _____ Address of Medical Provider: _____

Name of Doctor (if known): _____

Witness Name (if any): _____

Lost time from work (if known): _____ Return to work date: _____

Loss Location Entity: _____

Address: _____

Contact Person: _____

Additional Information

Job Classification code: _____

Time the employee began work on the day of injury: _____

Supervisor Notice Date: _____ Claim Incident Number: _____

This is assigned by NetClaim.net (at the FINISH tab) or by the Hotline operator.

Rev. 021014

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

(for WCC use only)

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)* FROM TO

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per

☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred

Contact Name | Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

This form is for reporting to Management and not to be submitted to the Insurance Company

Instructions for completion of this form:

- Complete the form in its entirety. Must be completed in addition to the First Report of Injury for every accident, injury or exposure involving employees volunteers or contract personnel.
- Fax to Employee Health at 706-721-0882 within 72 hours of the incident.
- All accidents/injuries/exposures must be reported regardless of the employee's desire/need to be seen by Employee Health or Emergency Services.

General Information

Name of Injured Employee:	Job Title:
Date of Incident:	Department:
Time of Incident: AM PM	Time Employee Shift Started: AM PM
Location of Accident:	Supervisor on Site:

Description of Accident, Injury or Exposure

Please be as detailed as possible. Describe in detail the duty/job the injured person was performing at the time of the accident. You may use reverse side for additional information.

What was the employee doing prior to the incident:
Describe what happened:
Name of Witnesses/Passengers:

Nature of Injury (Be as Specific as Possible)

Body Part Injured:
Describe object or substance that directly harmed employee:
Type of Injury:
If Other, please provide additional information:
Treatment Provided: ☐ No Treatment ☐ First Aid (Employee Health) ☐ Emergency Room ☐ Other: _____

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SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

This form is for reporting to Management and not to be submitted to the Insurance Company

If the employee missed any time from work due to this injury, what was the first day of missed work?
If employee is still out of work, how long will the employee be away from work?
If the employee has returned to work, on what date did the employee return?

Corrective Measures Taken Following Accident

Supervisor Completing Report

Name:	**Job Title:**	
Date:	**Extension:**	**Department #:**

Do not write below line

Review/Recommendations

Reviewer:	**Date of Review:**

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SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION REPORT

FILE NO.: DATE: / /

Date of Accident: / /	**Time of Day : AM : PM**
Date Reported: / /	**Accident Occurred On Employer's Premises?: ☐ Yes ☐ No**
Supervisor's Name:	**Telephone No.:** ( ) -
Dept./Univ.:	**Address:**
Division:	**City:**
Location of Accident (specify site within facility):	
Witnesses Name:	**Day Telephone Number:** ( ) -
Witnesses Name:	**Day Telephone Number:** ( ) -

PERSONAL INJURY

1. Name of Injured:
2. Social Security #: xxx-xx- Home # ( ) - Work #: ( ) -
3. Home Address:
4. Sex: ☐ Male ☐ Female 5. Age: 6. Job Title:
7. Employment Date: / / 8. Hrs Wrk Day: Hrs Wrk/Week:
9. Time on Current Job: (yrs) (mos) ☐ Full-time ☐ Part-time ☐ Temporary ☐ Seasonal

Employee Required: ☐ First-Aid Only ☐ Medical Treatment ☐ Fatality / / (date of death) ☐ OSHA Recordable

Employee Disposition Status ☐ Returned to Work ☐ Sent Home ☐ To Doctor ☐ To Hospital	☐ Other *Explain:*

PROPERTY DAMAGE

☐ Does not apply ☐ Major ☐ Serious ☐ Minor

[ ] Vehicle [ ] Equipment [ ] Private Property

Vehicle I.D:. **Model:** **Age:** (yrs) (mos) **Driver's License #:**	**Equipment I.D.:** **Model:** **Age:** (yrs) (mos)

Name & Title of person with most direct responsibility for employee involved in this accident:	**Employee Description of Accident/Incident:**
IMMEDIATE CAUSE(s) ☐ Equipment ☐ Personnel ☐ Environment ☐ Mgt. ☐ Hazardous Conditions ☐ Unsafe Act	*Explain:*
BASIC CAUSE & CONTRIBUTING FACTOR(s) ☐ Environmental conditions ☐ Personnel ☐ Hazardous conditions ☐ Management ☐ Lack of safety instruction & training	*Explain:*
CORRECTIVE ACTION: I have taken the following: ☐Temporary / ☐Permanent immediate actions to reduce recurrence	*Explain:*
I recommend the following actions(s) to prevent recurrence, and anticipate completion by: / / date	
Managers Comments: (Appropriateness of Cause & Corrective Action)	**Signature:**_____ **Title:** **Telephone:** ( ) - **Date:** / /
Corrective Action/Follow up By Department Manager/Safety Officer:	**Date:** / /
Reviewed by Director:	**Date:** / /

Distribution: Director, WC Administrator, Safety & Health Director

COMPLETE FOLLOWING CHECKLISTS

ACCIDENT OR INCIDENT BREAKDOWN BY CHARACTERISTIC

NATURE OF INJURY

- ☐ No Physical Injury
- ☐ Amputation
- ☐ Angina Pectoris (Heart Disease)
- ☐ Burn (heat, chemical)
- ☐ Concussion
- ☐ Contusion (bruise, hematoma)
- ☐ Crushing
- ☐ Dislocation (nerve, disc, tear)
- ☐ Electric Shock (electrocuted)
- ☐ Enucleation
- ☐ Foreign Body (lint in eye)
- ☐ Fracture
- ☐ Freezing (frost bite)
- ☐ Loss of Hearing (traumatic)
- ☐ Heat Prostration
- ☐ Hernia (from lifting)
- ☐ Infection
- ☐ Inflammation
- ☐ Laceration
- ☐ Myocardial Infarction
- ☐ Poisoning (not cumulative)
- ☐ Puncture (needle stick)
- ☐ Rupture
- ☐ Severance
- ☐ Sprain
- ☐ Strain
- ☐ Syncope (fainting, etc.)
- ☐ Asphyxiation
- ☐ Vascular (includes strokes)
- ☐ Vision Loss
- ☐ All Other Specific Injuries
- ☐ Dust Disease
- ☐ Asbestosis (lung disease)
- ☐ Black Lung (coal)
- ☐ Byssinosis (cotton)
- ☐ Silicosis (silica dust)
- ☐ Respiratory Disorders
- ☐ Poisoning - chemical
- ☐ Poisoning - metal
- ☐ Dermatitis (any skin irritation)
- ☐ Mental Disorder
- ☐ Radiation (tissue, bones, etc.)
- ☐ Other Occupational Diseases
- ☐ Loss of Hearing
- ☐ Infectious Disease
- ☐ Cancer
- ☐ AIDS
- ☐ VDT Related Disease
- ☐ Mental Stress
- ☐ Carpal Tunnel Syndrome
- ☐ Other Cumulative Injuries
- ☐ Multiple Physical Injuries Only
- ☐ Multiple Injuries, Physical & Psych.

PARTS OF BODY AFFECTED

- ☐ Head
- ☐ Skull
- ☐ Brain
- ☐ Ear(s) (eardrum)
- ☐ Eye(s)
- ☐ Nose
- ☐ Teeth
- ☐ Mouth (lips, tongue, throat)
- ☐ Facial Soft Tissue
- ☐ Facial Bones
- ☐ Neck (multiple injuries)
- ☐ Vertebrae
- ☐ Disc (neck, spinal column)
- ☐ Spinal Cord
- ☐ Larynx (vocal cords)
- ☐ Soft Tissue (neck)
- ☐ Trachea
- ☐ Upper Extremities
- ☐ Upper Arm (humerus)
- ☐ Elbow (radial head)
- ☐ Lower Arm (forearm)
- ☐ Wrist
- ☐ Hand (excluding wrist, fingers)
- ☐ Thumb
- ☐ Shoulder(s) (armpit, rotator cuff)
- ☐ Wrist(s) & Hand(s)
- ☐ Trunk (combination parts)
- ☐ Upper Back (thoracic area)
- ☐ Low Back (lumbar etc.)
- ☐ Disc (back)
- ☐ Chest (ribs, sternum etc.)
- ☐ Sacrum & Coccyx
- ☐ Pelvis
- ☐ Spinal Cord
- ☐ Internal Organs
- ☐ Heart
- ☐ Lower Extremities
- ☐ Hip
- ☐ Thigh, Upper Leg
- ☐ Knee
- ☐ Lower Leg
- ☐ Ankle
- ☐ Foot
- ☐ Toe
- ☐ Great Toe
- ☐ Lungs
- ☐ Abdomen
- ☐ Buttocks
- ☐ Lumbar & or Sacral Vertebrae
- ☐ Artificial Appliance
- ☐ Insufficient Info to Identity
- ☐ No Physical Injury
- ☐ Multiple Body Parts
- ☐ Body Systems

TYPES OF ACCIDENTS

A. Burn or Scald-Heat or Cold Exposure:
- ☐ Chemicals
- ☐ Touched Hot Pan
- ☐ Temperature Extremes
- ☐ Fire or Flame
- ☐ Boiling Water Splashed
- ☐ Dust, Gases, Fumes etc.
- ☐ Caught In, Under, or Between
- ☐ Welding Flash - Injury to Eyes
- ☐ Radiation
- ☐ Contact with, NOC
- ☐ Cold Objects/Substances
- ☐ Abnormal Air Pressure
- ☐ Electric Current

B. Caught In, Under or Between:
- ☐ Machine or Machinery
- ☐ Caught, In, Under or Between
- ☐ Collapsing Materials (earth slides)

C. Cut, Puncture, Scrape:
- ☐ Broken Glass
- ☐ Hand Tool, Utensil
- ☐ Object Being Lifted
- ☐ Powered hand Tool
- ☐ Cut, Puncture, Scrape

D. Fall, Slip or Trip:
- ☐ Fall From Different Level
- ☐ Fall From Ladder
- ☐ Fall From Liquid/Grease
- ☐ Fall Into Opening
- ☐ Fall on Same Level
- ☐ Slipped, Did Not Fall
- ☐ Fall, Slip or Trip
- ☐ Ice or Snow
- ☐ Stairs

E. Motor Vehicle:
- ☐ Crash of Water Vehicle
- ☐ Crash of Rail Vehicle
- ☐ Collision w/other Vehicle
- ☐ Collision w/fixed Object
- ☐ Crash of Airplane
- ☐ Vehicle Upset (overturned)
- ☐ Motor Vehicle, NOC

F. Strain:
- ☐ Continual Noise
- ☐ Twisting
- ☐ Jumping
- ☐ Holding or Carrying
- ☐ Lifting (including patients)
- ☐ Pushing or Pulling
- ☐ Reaching (overhead)
- ☐ Using Tool or Machine
- ☐ Strain of Injury
- ☐ Throwing or Welding
- ☐ Repetitive Motion (CTS)

G. Striking Against or Stepping On:
- ☐ Moving Machine Parts
- ☐ Object Lifted or Handled
- ☐ Standing, Scraping Operator
- ☐ Stationary Object
- ☐ Stepping on Sharp Object
- ☐ Striking or Stepping

H. Struck or Injured By (kicked, stabbed, bit):
- ☐ Fellow Worker, Patient
- ☐ Falling or Flying Object
- ☐ Hand Tool or Machine
- ☐ Motor Vehicle
- ☐ Moving Parts of Machine
- ☐ Object Lifted or Handled
- ☐ Object Handled by Others
- ☐ Struck or Injured
- ☐ Animal or Insect
- ☐ Explosion or Flare Back

I. Rubbed or Abraded By:
- ☐ Repetitive Motion
- ☐ Rubbed or Abraded, NOC

Distribution: Director, WC Administrator, Safety & Health Director

Hazardous Condition

- ☐ Inadequate Ventilation
- ☐ Insufficient Workspace
- ☐ Improper Illumination
- ☐ Environmental Hazard
- ☐ Use of Inherently Hazardous Material
- ☐ Use Inherently Hazardous Method or Procedure
- ☐ Use of Inadequate or Improper Tools or Equipment
- ☐ Inadequate Help for Heavy Lifting
- ☐ Improper Assignment or Personnel
- ☐ Hazardous Methods or Procedures
- ☐ Improperly Placed
- ☐ Inadequately Secured
- ☐ Unguarded, Mechanical
- ☐ Inadequate Shoring
- ☐ Ungrounded
- ☐ Uninsulated
- ☐ Uncovered Connection Switches, etc.
- ☐ Unshielded Radiation
- ☐ Inadequately Guarded, NEC
- ☐ Public Hazards (off State Premises)
- ☐ Traffic Hazards
- ☐ Hazardous Condition, NEC
- ☐ Undetermined-Insufficient Information
- ☐ No Hazardous Condition

Unsafe Act

- ☐ Cleaning, Oiling, Adjust Moving Equipment
- ☐ Welding/Repairing of Equipment Without Supervisor
- ☐ Working on Electrically Charged Equipment
- ☐ Failure to Secure or Warn
- ☐ Failure to Shut off Equipment Not in Use
- ☐ Failure to Place Warning Signs & Signals
- ☐ Releasing or Moving Loads, etc., Without Giving Adequate Warning
- ☐ Horseplay, Fighting, etc.
- ☐ Use of Equipment or Material for Other Than its Intended Purpose
- ☐ Overloading
- ☐ Gripping Object Insecurely
- ☐ Taking Wrong Hold of Object
- ☐ Using Hand Instead of Tools
- ☐ Inattention to Footing or Surroundings
- ☐ Disconnecting or Remaining Safety Devices
- ☐ Replacing Safety Devices With Those of Improper Capacity
- ☐ Jumping From Elevations, Vehicles, etc.
- ☐ Running
- ☐ Throwing Material or Tools
- ☐ Riding in Unsafe Position
- ☐ Unnecessary Exposure Under Suspended Loads
- ☐ Unnecessary Exposure to Moving Materials or Equipment
- ☐ Driving Too Fast or Too Slowly
- ☐ Entering/Leaving Vehicle on Traffic Side
- ☐ Failure to Signal When Stopping, Turning or Backing
- ☐ Failure to Yield ROW
- ☐ Backing Without Looking for Clearance
- ☐ Failure to Obey Traffic Control Signs or Signals
- ☐ Following Too Close
- ☐ Other (Explain)

Supervisory Activities

- ☐ Inadequate Training of Employee
- ☐ Faulty Instruction to Employee
- ☐ Improper Planning of Job
- ☐ Unsafe Procedures of Job
- ☐ Inadequate Knowledge/Leadership
- ☐ No Supervisory Failure

Employee Attributes

- ☐ Lack of Knowledge or Experience
- ☐ Improperly Trained
- ☐ Bodily Defects
- ☐ Lack of Respect for Hazard
- ☐ Other Insufficient Data
- ☐ DWI

Safety Equipment in Use

- ☐ Hard Hat
- ☐ Safety Glasses
- ☐ Respirator
- ☐ Movable Exhaust Hood
- ☐ Ear Protection
- ☐ Safety Shoes
- ☐ Lanyards & Lifelines
- ☐ Fluorescent Vest ☐ Flags
- ☐ Buoyant Workvest
- ☐ Chemical Apron
- ☐ Faceshields ☐ Gloves
- ☐ Warning & Control
- ☐ Seat Belts
- ☐ Shoulder Harness
- ☐ Other Restraining Devices
- ☐ Safety Equipment

PREPARE & ATTACH SKETCH AND/OR PROVIDE PHOTOS AS NECESSARY TO DESCRIBE ACCIDENT/INCIDENT

RETURNING TO WORK/MODIFIED DUTY

Although an employee suffering workers' compensation injury may not be able to perform all of the duties of his position, a physician may return an employee to work under modified duty. Modified duty clearance requires the employee to report to work each day and perform job duties in accordance with his/her physical limitations. It is important that Department Heads work with the workers' compensation carrier to create modified duty work so that employees can return to work as soon as possible.

Examples of modified duty are:

- Filing or other paper work
- Cleaning work areas or tools
- Picking up trash-with or without bending assistance tools
- Answering phones
- Watching training videos
- Light repair work
- Painting

An employee cannot return to work until he/she is cleared to return to work by a physician.

TOWN OF DARIEN

HUMAN RESOURCES DEPARTMENT

W. LEE PALMER
DIRECTOR

RETURN TO WORK FORM

Mr. /Mrs. /Ms. _____ was seen in my office

on _____ and:

Has been unable to work since: _____

Can return to work effective: _____

_____ Without any Restrictions

_____ With the Following Restrictions

_____

_____

_____

Is unable to return to work at this time, but will be reevaluated on _____

I have reviewed the job description for this patient and certify that he/she is able to perform the essential functions of the job _____ (initial)

_____ _____

Name of Physician/Person completing form Date

Address: _____

Phone Number: _____

Please complete and mail this form to the Human Resources Department at the address below or Fax to (203) 656-7389

MATERNITY LEAVE

Pregnant employees are eligible for leave in connection with the birth of a child under the FMLA. Prior to the birth of the child, the employee should obtain an FMLA leave request form and have her physician complete it. Unless otherwise stated by the physician, the leave will begin when the physician certifies that the employee is "disabled" from performing her normal duties and responsibilities. The first 6-8 weeks following the birth of the child are normally considered sick leave (6 weeks for vaginal delivery and 8 weeks for caesarean birth). If the employee does not have sufficient sick leave to be paid for the 6-8 weeks, she must utilize accrued vacation or personal time following the depletion of sick time for the duration of the leave. If the employee does not have sufficient accrued paid time for the duration of the leave, part of the leave may be unpaid. Sick leave may not be used beyond the 6-8 weeks without a physician's note certifying a continuing illness, injury, or medical condition.

In the event of an unpaid leave, the employee is responsible for paying the insurance deductions that would have been made from his/her paycheck. The employee should submit payment to the Finance Department to cover the employee share of medical and dental to insure the continuation of benefits.

MILITARY LEAVE

Employees who are members of the National Guard or a reserve component of the U.S. Armed Forces and a permanent employee are entitled to military leave to attend required training. The employee must submit a copy of his/her military orders to the Human Resources Department to verify the leave. Also any employee who leaves or had left Town employment for the purpose of entering the armed forces of the United States has a right to be reinstated in his/her former position and duties, provided he/she provides Human Resources with a certificate of satisfactory service from the armed forces and makes an application for return to employment.

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number 1235-0003
Expires 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

A copy of the military member's covered active duty orders is attached.

Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

If so, estimate the beginning and ending dates for the period of absence:

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes☐ No☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.

CONTINUED ON NEXT PAGE

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. T he Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

Certification for Serious Injury or Illness of a Current Servicemember - -for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 5/31/2018

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

_____

Name of Employee Requesting Leave to Care for the Current Servicemember:

_____

First Middle Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

_____

First Middle Last

Relationship of Employee to the Current Servicemember:

Spouse☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes☐ No☐

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
Yes☐ No☐

If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the servicemember require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes☐ No☐

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE EMPLOYEE

OMB Control Number: 1235-0003
Expires: 5/31/2018

Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

INSTRUCTIONS to the EMPLOYEE and/or VETERAN: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

_____

Name of employee requesting leave to care for a veteran:

_____
First Middle Last

Name of veteran (for whom employee is requesting leave):

_____
First Middle Last

Relationship of employee to veteran:

Spouse☐ Parent☐ Son☐ Daughter☐ Next of Kin ☐ (please specify relationship):

Part B: VETERAN INFORMATION

(1) Date of the veteran's discharge:

_____

(2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes☐ No☐

(3) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

_____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

Type of Practice/Medical Specialty: _____

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider

PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran's medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the veteran require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

CONTINUED ON NEXT PAGE

(3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?
Yes☐ No☐

(4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part "A" above).**

JURY DUTY

Employees who have been called to serve on jury duty must provide their supervisor with a copy of the jury duty subpoena and the days of service. The supervisor is responsible for notifying payroll of an employee's jury duty so that the employee can continue to receive his/her regular pay. However, an employee is expected to report to work on any days in which he/she is not required by the court to report.

HIRING A TEMPORARY EMPLOYEE

When a Department Head becomes aware that an employee may be out of work for an extended period of time due to injury or illness, he/she may need to hire a temporary employee to fill in during the permanent employees' absence.

The Department Head should contact Human Resources to assist in identifying appropriate individuals for the temporary assignment and possible funding sources.

III. WHAT TO DO WHEN THE EMPLOYMENT RELATIONSHIP ENDS

Most instances when an employee separates from Town employment are voluntary resignations or retirements. However, occasionally, an employee leaves because his/her position is eliminated or his/her employment is involuntarily terminated.

If an employee gives you notice of his/her intent to resign or retire, the supervisor should ask the employee to put his/her intent to resign/retire in writing and include the last date of employment. Although it is not required, a two-week notice period is requested to permit the Town sufficient time to begin the recruitment process and transition of duties. An employee should not be granted vacation or personal leave time during the "notice period" except under special circumstances. An employee who uses sick time during his/her resignation period is subject to the same physician documentation requirements as other employees and subject to the same disciplinary action as other employees suspected of sick leave abuse.

If you are considering involuntarily terminating an employee's employment, it is imperative that you contact Human Resources before you take any steps to insure that termination is warranted and that the employee is provided with appropriate due process and/or union representation.

If an employee is terminated or laid off, the Town is required to provide him/her with a final paycheck and "pink slip" for the purpose of filing a claim for unemployment within a specific time frame. Therefore, it is important to provide the Human Resources Department with as much advance notice as possible of the employee's anticipated last date of employment so his/her final paycheck and unemployment papers can be prepared and delivered in the required time frame.

If the employee has any Town property, please make sure it is returned before the employee's final day of employment.

If you have questions about a personnel procedure or form that is not addressed in this guide, please contact the Human Resources Department at (203) 656-7390.

Town of Darien
EMPLOYEE CHANGE OF STATUS REPORT

Name:	**Department**
Effective Date:	**Employee ID Number:**
Job Number:	**Position Number:**

CHANGE	FROM:	TO:
Department		
Organizational Code		
Job Title		
Grade/Step		
Rate of Pay		
Bargaining Unit		

REASON FOR CHANGE			
New Hire	**Re-hire**	**Promotion**	**Transfer**
Reassignment	**Resignation**	**Retirement**	**Layoff**
Discharge	**Leave of Absence**	**From:**	**To:**
Other (Explain):			

APPROVALS	
Department Head:	**Date:**
Human Resources:	**Date:**
Finance/Payroll:	**Date:**
Town Administrator:	**Date:**